ART

Freud's Sculpture

An exhibition at the Henry Moore Institute, Leeds, until 23 April; the Freud Museum, London, from 6 May until 2 July 2006
www.henry-moore-fdn.co.uk/

Rating: ★★★☆

This year, 6 May to be precise, is the 150th anniversary of the birth of Sigmund Freud. One event marking this is an exhibition of 12 small scale sculpted figures—representative of the changing group of favourites Freud kept on his desk—selected from the eclectic collection of 2000 Egyptian, Greek, Roman, Chinese, and near Eastern antiquities he amassed between 1896 and 1939.

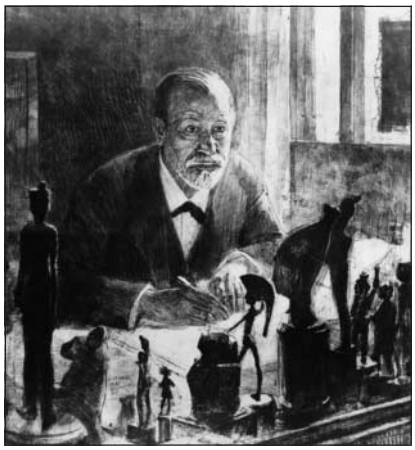
Originally displayed in his study and consulting rooms at Berggasse 19 in Vienna, Freud's collection has since 1938 been housed at 20 Maresfield Gardens, Hampstead, where he spent the last few months of his life after fleeing the Nazis. When he died, his youngest daughter, Anna, left his study and library untouched. It was crammed with his furniture, books, and antiquities. In 1986, four years after her death, the house and its contents became the Freud Museum. One of the most evocative houses in London, it retains a palpable sense of rare intellectual curiosity and achievement.

Freud's sculpture collection effectively constitutes a museum of his own creation, within the house. The museum hosts a continuing programme of installations by contemporary artists whose work engages with Freud's ideas, and it has lent pieces for exhibitions previously. What makes the current show, at the Henry Moore Institute, unique, however, is that visitors are able to view the figures as closely as Freud did, when seated at his desk in Vienna and Hampstead.

The sculptures are arrayed on a desk-shaped plinth and visitors are able to sit in a replica of his desk chair and engage with the works at an intimate, Freud-eye level, which is impossible in Hampstead, where his desk is roped off at a distance. The bizarrely shaped chair itself, originally commissioned by Freud's eldest daughter, Mathilde, to accommodate his "habit of reading in a very peculiar and uncomfortable body position," is open to multiple interpretations and resonates with meaning.

The show explores our understanding of Freud's relationship with his collection of antiquities. Max Pollack's 1913 etching, the first image of Freud with his sculptures, hangs on the wall behind the "desk." It shows him seated at his desk in the half light of his Viennese study, his gaze fixed above their silhouetted shapes. In 1934 Freud's patient the American poet Hilda Doolittle recorded him saying that his "little statues and images helped stabilize the evanescent idea, or keep it from escaping altogether."

In his catalogue essay, Ivan Ward observes that Freud's figures occupy desk space that lesser intellects might use to house their reference books; however, it was available to Freud for displaying his favourites because he separated the process of writing from his reading. Michael Molnar comments, in his catalogue essay, that the row of figures resembles an audience gathered around Freud's writing paper, forming a totality with the collector and representing his journey from inspiration to inscription.



COURTESY OF THE FREUD MUSEUM

Sigmund Freud at his desk. Max Pollak, 1913

Freud never analysed his own passion for collecting, although he counted it alongside smoking as one of his two addictive pleasures. John Forrester observed in a chapter he contributed to *The Cultures of Collecting* (Reaktion Books, 1994) that Freud's collection of antiquities mirrored his collections of dreams, case histories, and anecdotes.

In fact, archaeology provided a metaphor for the techniques and theories of psychoanalysis from the beginning, and one of Freud's favourite terms for his patients' forgotten, infantile pasts was "prehistoric." He told his patient Wolf Man, "The psychoanalyst like the archaeologist in his excavations must uncover layer after layer of the patient's psyche before coming to the deepest most valuable treasures."

Unarguably, Freud's first acquisitions were an almost explicit response to his father's death in 1896—in his words "a source of exceptional renewal and comfort." Freud also believed that some collect as a substitute for sexual conquests.

When his antiquities had been put back in their respective places in Hampstead, using diagrams made before they were packed up in Vienna, Freud wrote that "a collection to which there are no new additions is really dead." He did, however, add a few pieces before dying in 1939.

HENRY MOORE INSTITUTE

Freud's eye view: visitors are able to look at the figures as closely as Freud did

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Items reviewed are rated on a 4 star scale (4=excellent)

PERSONAL VIEWS

Independent sector treatment centres: how the NHS is left to pick up the pieces

There is no doubt that the expansion of orthopaedic services, provided by the Department of Health through private hospitals and independent sector treatment centres (ISTCs), has been a much needed development, but it has occurred at a price. Admittedly there are many patients who have benefited from the development of ISTCs and are now leading pain free lives as a result of surgery carried out much earlier than would have been possible in the early 1990s, when our health service was grossly underfunded. However, the number of patients we are seeing with problems resulting from poor surgery—incorrectly inserted prostheses, technical errors, and infected joint replacements—is too great.

Perhaps we should look at the mechanisms through which this whole ISTC exercise has been carried out. Surgeons from overseas have been flown into the United Kingdom to increase the numbers available to provide elective orthopaedic services. They have come from many countries, usually European, and their training and clinical practice at home are quite different from those to which they are exposed in an ISTC.

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In Germany, Hungary, and Croatia, for example—countries I know about because I have visited surgical centres in all of them—the junior specialist usually attends rounds first thing in the morning, during which the planned operations for the day are presented and discussed with the senior consultant. The senior consultant then instructs the junior specialist about which operation is to be carried out and how, and the junior specialist then goes off and performs the surgery. The x ray result of this surgery is presented at subsequent rounds. Clearly there is careful supervision of the relatively inexperienced specialist.

What has happened in ISTCs is that these junior specialists have been imported and asked to provide total surgical care without help and supervision from a more senior colleague—a situation that is alien to many of them. They do not have a senior colleague to turn to for help with difficult cases, nor if things go wrong—hence the reason why the failures find their way to the NHS hospitals.

This situation has arisen because of a political philosophy called "additionality." When former health secretary Alan Milburn set up ISTCs there was clearly concern that their development might result in NHS hospitals losing some of their own surgical staff. To ensure that this could not happen a six-month rule was imposed—an NHS surgeon could not work in an ISTC until he or she had stopped working for the NHS for six months. While this ensured that the NHS hospitals were protected from losing their own staff, it also meant that the ISTCs did not have access to many, or any, senior surgeons who could act as senior consultants and help their colleagues when they ran into trouble. Now we are seeing the consequences of this philosophy—poor operations, inadequate supervision of surgeons, and a poor mechanism for remedying any problems that occur.

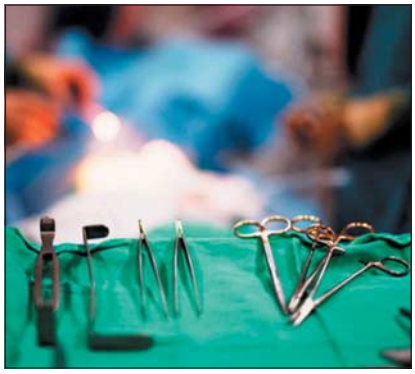
The NHS has, in the past decade, emphasised the importance of clinical governance. I am aware, as a result of discussions with industry representatives and theatre staff who have moved to ISTCs, that there are many clinical governance issues that the new systems appear not to have addressed. For example, many overseas orthopaedic surgeons have been asked to carry out joint replacement operations that they have never seen or done before.

Because of the single supplier contracts that many of the ISTCs now have, only one joint replacement type is available to the surgeon and that is the joint that he or she is asked to put in. It is clear that this has occurred with inadequate training of both the surgeons and the operating theatre staff and as a consequence there have been several serious errors—joint replacements put in without bone cement when bone cement was essential for that joint replacement, the use of the incorrect size heads (ball) for a hip joint replacement, etc.

> We are frustrated by the artificially created divide between the ISTC and the NHS hospital

There is also a difference in the rules that apply to staff. NHS consultants have to attend regular hospital audit meetings, their clinical director oversees them in their NHS work, and they have an obligatory annual appraisal system. It is not clear how these procedures are being addressed in ISTCs and this creates a suspicion by NHS staff that corners have been cut in achieving the goals of high productivity and throughput.

Perhaps the issue that should be of most concern, however, is that of training the country's up and coming surgeons. The "straightforward" cases, now dealt with by the ISTCs, had been the cases on which young surgeons learnt their craft, firstly by observing the consultant, and then by performing parts of the operation under the consultant's supervision; when fully competent, they would conduct the operation themselves with the consultant present or available in the hospital. This time honoured and soundly proved method of training has now, sadly, been denied. Even if training were to be allowed in ISTCs, the supervising surgeons may not be fully competent themselves, as previously mentioned, let alone competent as trainers. Consequently the competence of our next generation of surgeons is in jeopardy.



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Cutting corners: how do ISTCs hit their targets?

We, as NHS staff, need to help, and many of us wish to, but we are frustrated by the artificially created divide between the ISTC and the NHS hospital.

Why has the problem with ISTCs, which have now been running for three years, not been aired and addressed before now? Firstly, Alan Milburn and prime minister Tony Blair wanted them to succeed despite any shortcomings. Subsequent health secretaries have taken similar views. Secondly, during the past 10 years NHS consultants have become increasingly fearful that if they publicly criticise the government or the Department of Health, by speaking up about their patients' problems and complications, then this will harm their own career and their future. This is a sad reflection on our opportunity to work with our government and our employers in addressing the problems arising within the modern NHS.

The government has created a two-level health service that is creating many problems. I believe that we should now integrate the ISTCs with the NHS instead of running them as a private healthcare system paid for by the state.

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Two decades on an ethics committee

I am in my 20th year of continuous service on research ethics committees and my 15th as an office holder. It is time to take stock. I do so aware that a lot has been written about ethics committees by researchers, most of it highly critical, whereas committee members have published much less about their experiences and views.

When I began, a senior colleague cautioned that ethics committee duties were not the route to wealth, prestige, or foreign travel: these were the privileges of the researchers. Our main rewards were intangible: protecting patients from bad research and contributing to the greater good. Altruism wasn't the only motivation, however: the work promised stimulating intellectual challenges and the ability to keep abreast of medical developments as they unfolded. And so it has proved.

What wasn't mentioned when I started was the workload. Currently, as a vice chair, I average eight hours a week on committee activities. As well as assessing and then discussing the 10 new submissions at the monthly committee meeting, I chair a weekly subcommittee that reviews about the same number of substantial amendments. There are inquiries to handle and occasional disputes to resolve, matters to discuss with our excellent administrative team, guidelines and operating procedures to review, and advice to give to healthcare and government bodies. Finally, there is continuing professional development, with usually two sessions a year devoted to enhancing our skills.

In the 1980s the research ethics world seemed much simpler. The Declaration of Helsinki informed our discussions and decisions, and we supplemented this when the need arose from those few guidelines that existed. We weren't hamstrung by "Europe," acts of parliament, regulations, and a clock obsessed set of standard operating procedures; nor were we working in a climate of constant criticism. I feel increasingly caught between a rock and a hard place as we try to protect patients from silly research and researchers from silly regulations.

How could the system be improved? I would start with three fundamentals.

Firstly, the application form remains alienating, despite face lifts and electronic titivation. Lord Warner's review of ethics committees in 2005 criticised it politely. I won't: it is a hybrid, chameleonic monstrosity. An ethics form should be distilled into no more than 10 questions, the content of which should be agreed by committees, researchers, and patients' representatives. Finally, the form should remain unaltered for five years rather than being continually amended: there is nothing more irritating for researchers than to be told they must resubmit because last year's version of the form is obsolete.

Secondly, there is the decision letter. It is infused with bureaucratic requirements, while its measure of performance is speed of reply rather than content. The key aim should be to ensure that communication from committees to researchers is informative and precise with regard to the rationale for rejection or for seeking changes to the design or to the consent procedures. It should not be a lesson in syntax, spelling, or punctuation, and it shouldn't be seen as an opportunity to impose a design that scientific members of the committee prefer.

Thirdly, if research ethics committees are riddled with faults, what about those who apply to them? It is a rare pleasure to receive a submission from an investigator who knows his or her subject and how to design a trial, who can convey this with care and consideration, who appreciates the importance of the ethical dimension in the work, and who can engage in constructive dialogue with the committee if a problem emerges. What we encounter far more often are researchers with ropey communication skills whose knowledge of their subject, research design, and ethical principles vary from passable to negligible.

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Sometimes this problem stems from senior researchers delegating submission to their trainees, research associates, or students or to the sponsoring drug company. But also there exist experienced researchers whose hostility to the process of ethical review is expressed in a slapdash approach to submission, coupled with a confrontational attitude to dialogue.

The solution has to be more education and better training. Colleges could consider providing high standard, formal accreditation courses for doctors who wish to undertake research. Chief investigator status, and thereby the authority to submit research to an ethics committee, would be conferred on researchers who had been appropriately trained.

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We welcome submissions for the personal view section. These should be no more than 850 words and should be sent electronically via our website. For information on how to submit a personal view online, see http://bmj.com/cgi/content/full/325/7360/DC1/1

SOUNDINGS

Privates on parade

Regional theatre is thriving in England, especially in Yorkshire, but without much support from doctors, I'm afraid. At a concert or the opera my wife and I often bump into music loving colleagues but in theatre bars we sip our dry white wine by ourselves. Still, it gives us a chance to look around.

Regional audiences are different from those in London's west end. Ours have hardly any tourists or star-struck fans, except when a celebrity vehicle is on tour.

In Britain, unlike in mainland Europe, theatregoers do not dress up, promenade, or socialise ostentatiously in the stalls. We are down to earth and stoical, and we try hard not to look middle class.

Our theatres keep saying they want to reach beyond their traditional audience base and we do our best to help. I wear my old trainers and we never speak aloud of Noel Coward. When the box office asks if we are unwaged we look embarrassed at having to say no. And if the programme warns about nudity we are careful not to nudge each other.

Frontal nudity these days involves only male actors. Farce has always involved someone losing his trousers but now, it seems, his underpants must drop as well. There is a characteristic noise that an audience makes when this happens—a sudden shriek of female hilarity. The effects of adrenalin on the chap in the spotlight mean that neither women nor men in the audience feel threatened.

Nevertheless it is distracting, particularly for an unsuspecting doctor in the front row. You look upwards with a fixed smile, trying to indicate that you are concentrating on the dialogue and the actor's subtle facial expressions. But the lights stay on, he jumps around a bit, and you begin to wish you were back in the fertility clinic. There at least you don't have to pay to get in.

Theatre reflects contemporary society, so perhaps it is no surprise that male actors are willing to accept humiliation while their female colleagues demand respect and stay dressed. I hope the boys catch up with them soon. Meanwhile, we aren't put off. We were part of a phlegmatic Sheffield audience for *The Romans in Britain* and we're off there again soon for a play entitled, ominously, *The Long and the Short and the Tall.*

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